



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN JACINTO METHODIST HOSPITAL
4401 GARTH RD
BAYTOWN TX 77521-2122

Respondent Name

LM INSURANCE CORP

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-11-1359-01

MFDR Date Received

December 27, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier continues to reduce claim drastically by applying a very high PPO reduction. Our First Health contract is a 95% discount of the TDI DWC fee allowables."

Amount in Dispute: \$2,140.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "PLEASE FIND THE ATTACHED INFORMATION, SHOWING THAT ADDITIONAL MONEY IN THE AMOUNT OF \$1734.13 WITH THE INTEREST OF \$24.01 HAS BEEN ISSUED IN REGARDS TO THE MDR M411-1359-01"

Response Submitted by: Gallagher Bassett Service, Inc., 6504 International Pkwy, Suite 2100, Plano, Texas 75093

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2010	Outpatient Hospital Services	\$2,140.91	\$304.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
5. 28 Texas Administrative Code §134.600 sets forth rules for prospective and concurrent review of health care.

6. 28 Texas Administrative Code §133.4 sets out requirements regarding written notification to health care providers of contractual agreements for informal and voluntary networks.
7. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL.
 - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVISE REMARKS CODES WHENEVER APPROPRIATE.
 - 96 – (96) NON-COVERED CHARGE(S).
 - 45 – (45) CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
 - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC
 - 18 – (18) DUPLICATE CLAIM/SERVICE.
 - 19 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Were disputed services appropriately denied for absence of authorization?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 45 – “(45) CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.” On January 26, 2011, the Division requested the respondent to provide documentation to support provider notification as required under 28 Texas Administrative Code §133.4. The respondent did not submit copies of the requested information. Again on March 15, 2011, the Division requested the respondent to provide documentation to support provider notification. Per §133.4(e), “Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption . . . in a medical fee dispute that the health care provider did not receive the notification.” The respondent failed to provide the requested documentation to support that the health care provider had been given the required notice. Pursuant to §133.4(g), which states that “The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if: (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section,” the Division concludes that that the respondent is not entitled to pay the requestor at a contracted rate for the services in dispute. Per §133.4(h), “If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement).” Consequently, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier denied procedure code 36415 with reason code 19 – “(197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.” Review of 28 Texas Administrative Code §134.600 (p) finds that specimen collection/venous blood collection is not among the non-emergency health care listed as requiring preauthorization. This denial reason is not supported. This service will therefore be reviewed per applicable Division rules and fee guidelines.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
- Procedure code J7040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.14. 125% of this amount is \$13.93. The recommended payment is \$13.93.
 - Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 26418 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0053, which, per OPPS Addendum A, has a payment rate of \$1,148.73. This amount multiplied by 60% yields an unadjusted labor-related amount of \$689.24. This amount multiplied by the annual wage index for this facility of 0.9933 yields an adjusted labor-related amount of \$684.62. The non-labor related portion is 40% of the APC rate or \$459.49. The sum of the labor and non-labor related amounts is \$1,144.11. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$572.06. This amount multiplied by 200% yields a MAR of \$1,144.12.
 - Procedure code 26756 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0062, which, per OPPS Addendum A, has a payment rate of \$1,742.08. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,045.25. This amount multiplied by the annual wage index for this facility of 0.9933 yields an adjusted labor-related amount of \$1,038.25. The non-labor related portion is 40% of the APC rate or \$696.83. The sum of the labor and non-labor related amounts is \$1,735.08. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,735.08. This amount multiplied by 200% yields a MAR of \$3,470.16.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2780 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Per Medicare policy, procedure code 93005 is unbundled from procedure code 26418 billed on the same date of service. Per Medicare policy, payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
5. The total recommended payment for the services in dispute is \$4,631.96. This amount less the amount previously paid by the insurance carrier of \$4,327.16 leaves an amount due to the requestor of \$304.80.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$304.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$304.80, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	September 28, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.